

In-Camera Report to the Board of Health,
Health Unit Structure Review

Appendix J

October 24, 2002

Subject:

In November 2001, the need to review the structure of the Health Unit was communicated to the Board of Health. It is the view of the management team of the Health Unit that although the last reorganization in 1999 was successful in addressing many issues, some important issues have persisted and become more acute.

From September 30 to October 15th, our organizational structure was reviewed by a team that consisted of senior management and the Chair of the Board of Health. The review was facilitated and documented in the appended report by the Planning and Evaluation Consultant.

Background:

Since January 1998, the Health Unit has had a structure which is flat and lean. There are only three levels to the organization (front-line staff, Directors, MOH / CEO), with a higher staff-to-management ratio when compared to the other eastern Ontario health units. With the last reorganization in 1999, the number of managers was increased by one position, making for a total of five directors and one Medical Officer of Health / Chief Executive Officer, compared to approximately 120 staff.

Despite this increase in directors, it is the view of the management team that this structure is excessively demanding of the directors, and does not provide front-line staff with sufficient consultative support. In part this has been due to the advent of a number of unanticipated public health issues (such as raccoon rabies, West Nile Virus, Walkerton / Beckwith / drinking water quality, anthrax / bioterrorism), and new programs and initiatives (such as enhancements in Healthy Babies Healthy Children, the Early Years Program, child development and reproductive health programs, infant hearing screening, Language Express, universal vaccination for influenza, the Tobacco Strategic Plan, as well as the Health Unit website and intranet system), with a resulting increase in demands on public health resources.

Such new issues place a disproportionate demand on the directors, as strategic analysis and decision making is required to ensure an appropriate response. In addition to this, the hiring of new staff associated with the ongoing rollout of the Health Unit's Long Range Resources Plan 1999 to 2004 requires the time of directors, and results in an even higher ratio of staff to management. Preparations for the accreditation survey in May, and the

commencement of negotiations of the collective agreements in April were major tasks requiring time from the directors.

In order to address these issues the need to formally review the organizational structure of the Health Unit was raised to the Board of Health in November 2001. In the spring of this year a private consulting firm conducted a review of our structure, however it was the view of both staff and the Board that their major recommendations would not be suitable for us. Because of this it was decided that we would conduct our own internal review. Given the demands on the Health Unit earlier in the year, and the difficulty in meeting over the summer months, it was decided to conduct the review in September and October.

The following information sources were considered by the structure review team (consisting of senior management and the Chair of the Board of Health) in their review:

- the Strategic Plan of the Health Unit
- the Board Report on the last Health Unit Reorganization in June 1999
- the results of the review of the Long Range Financial Plan
- the findings of the focus-group sessions with staff
- the consultants' report on the structure of the Health Unit
- the draft Quality Improvement Plan of the Health Unit
- the organizational charts of other health units
- other sources, such as information from the Language Express Program on how Speech and Language Programs fit within the structure of other health units in the province

The report in Appendix B documents the process by which the structure of the Health Unit was reviewed. The purpose of the review was to determine what changes to our structure we would recommend to the Board in order to optimize our operations to fulfill our mandate. Figure 1 on page 2 of the report lists the *guidelines* that were used in this process. These guidelines were developed early in the process to serve as criteria to evaluate the options for alternative structures. The advantages and the disadvantages for the present structure are documented on pages 2 and 3.

A number of potential structures were generated and reviewed, as documented in the report. By the end of the review, the structure in Appendix A was chosen unanimously by the team.

This structure retains the four program delivery departments that we presently have, although the names of these departments have been modified in keeping with the preference of their respective directors. Further work may be done at a later point in the modification of these department names. The following two departments would be allocated managers: Health Protection (one manager) and Family Health (one manager for Healthy Babies Healthy Children, one manager for Speech and Language).

In addition to this, a new Quality Improvement Department would be created, with a Quality Improvement Manager. The Quality Improvement Department would have a number of staff who are presently within the Office of the MOH and Corporate Services. This department would also manage the use of funding for the equivalent of one full-time-equivalent of contracted personnel time. This funding (which is in the present budget) would be used to support the needs of the program departments for special projects such as the development of program materials or projects, or to support special investigations. The role of this department overall would be to facilitate the implementation of the Quality Improvement Plan of the Health Unit and the maintenance of agency compliance with accreditation standards. This is in keeping with the goal regarding continuous quality improvement within the Strategic Plan of the Health Unit.

In total there would be the creation of four manager positions. Two of these positions would be created from the following presently existing positions and thus would not represent a significant additional cost: the Quality Improvement Coordinator, and the Speech and Language Coordinator. With only two of the four manager positions being new, the additional cost of the new structure is estimated to be \$110,000.

In addition, it is recommended that the Clinical Services Department and the Healthy Lifestyles Departments would be provided with a manager if at some point in the future they experience significant staff growth.

The team sought to generate a proposed structure that would address the many desired outcomes listed in Figure 1 – Guidelines for the Health Unit Structure, on page 2 of the appended report. Throughout the process consideration was made of the results of the staff focus groups that were conducted earlier in September (see Appendix C).

A number of potential structures were generated and reviewed for their ability to address our needs. It was apparent that each of these structures had their respective advantages and disadvantages. In addition, many issues were noted to be more appropriately addressed by means other than agency structure, such as by the development of policy, and by clear and consistent communication.

The proposed structure was chosen because it was the overall unanimous view of the team that it was the most preferable of all the structures considered. It would provide enhanced management support to the two departments with the greatest present need for this, with regard to management span of control, staff support, and the need for risk and liability management. In addition, the conversion of the Language Express Coordinator into a Manager would allow this position to conduct performance appraisals and to submit purchase orders, which would address some issues that have been noted for this program. The structure would be adaptable over time, and allow for the addition of further supports to staff and management that may be needed if we experience significant growth in the years to come.

The availability of funding for one FTE of contracted time to do special projects will continue to function as a support to all the program departments. This funding, which at presently is equally distributed among the four program delivery departments, would be administered by the Quality Improvement Department throughout the Health Unit on an as-needed basis. This would serve to provide added support to all the departments, and in particular to Healthy Lifestyles and Clinical Services.

The creation of a Quality Improvement Department is consistent with the Health Unit's Strategic Plan, the structure review team's structure review Guidelines, the recommendations of the private consultants' report (in terms of the assignment of quality improvement resources "on a full-time basis"), and with the findings of the staff focus groups. The mandate of this department would be to promote the implementation of continuous quality improvement (CQI) principles and methods throughout the Health Unit by fulfilling our Quality Improvement Plan. The Quality Improvement Manager would be a member of the Senior Management Committee in order to allow for this mandate to be fulfilled. This Manager would also supervise the Department, which would consist of the positions identified within the Organizational Chart. These positions were chosen for this department because they are felt to be highly linked with CQI and with the service and support to the other departments. These staff positions are presently found within Corporate Services and the Office of the MOH. Thus their placement within the Quality Improvement Department would reduce the span of control and management burden on the Director of Corporate Services and on the Medical Officer of Health. The Quality Improvement Manager position would be created from the presently existing position of the Quality Improvement Coordinator at no anticipated additional cost.

The team decided to retain the four program delivery departments for several reasons. Overall program delivery and compliance with the Mandatory Programs under this structure has continued to improve over time, demonstrating the structure's ability to deliver service. Consideration was made regarding the potential to merge Health Protection and Clinical Services in order to address the overlap between these two departments in the management of outbreaks of communicable diseases and infection control activities. It was noted however, that having a director exclusively devoted to the programs within Clinical Services has allowed for significant issues to be effectively addressed, and that significant challenges remain to which a director would be more empowered to respond. Also it is essential that there be close collaboration between the Medical Officer of Health and the outbreak team staff, and that adding another layer may hamper this. The need for staffing support from other departments to respond to outbreaks and other needs within Clinical Services was seen by the review team as being part of the broader issue of interdepartmental collaboration and the prioritization of program delivery based on need and impact. This issue will be addressed by the development of policy.

Corporate Services would continue to manage finance, human resources, computer systems, purchasing and the floating clerks. Consideration will be given to the possibility that the receptionists be within this department as well. The structure review team

carefully considered the recommendation from the staff focus groups that human resources be managed in a separate department from finance. An informal survey of other health units found that only those that were part of a regional municipal government have this arrangement. The decision to keep human resources and finance together was supported by the private consultants' report. It is the view of the review team that human resources and finance are complementary functions and that separating them can only be justified for large organizations. When discussing the issue, the team noted that there is the perception among staff that having these two functions in one department creates an imbalance of decision-making authority and a conflict of interest. In reality, the creation and implementation of the budget each year is a collaborative function that involves all Senior Management Committee (SMC) members. The identification of human resource needs and the allocation of human resources is done collaboratively by SMC members. Staff development activities are in part determined within departments by their respective Staff Development Committees. Likewise, the fulfillment of agency policy and collective agreements is a shared responsibility of all members of the agency. The structure review team agreed to communicate clearly and consistently on these matters with staff on an ongoing basis in order to better address the related concerns.

The need for role clarification was identified by staff and recognized by the structure review team. The report in Appendix B contains a listing of Role and Responsibilities within Figure 4 on page 8. The importance of continuing to foster leadership throughout the agency was recognized as essential. Thus it is very important that the new managers would serve as a supporting and enabling resource to staff, and to foster continued leadership by staff, in keeping with the principles of continuous quality improvement. The leadership roles of Team Leaders and Coordinators would continue as before. In addition, the Quality Improvement Manager and Department will work to foster this general approach to management throughout the Health Unit. Further communication would be done among management and staff on an ongoing basis to ensure role clarity and appropriateness.

The issues related to geography and the equitable provision of services to a dispersed rural population were reviewed by the team. It was decided that each of the outer offices would be assigned one of the program directors to manage office issues. To facilitate this, these directors would visit their respective offices no less often than every two months. The assignment of the directors to the offices would be reviewed annually early in the year. In addition, a member of management will have their office in Smiths Falls. These are in keeping with the recommendations from the staff focus groups.

The review team discussed the potential merits of having staff in the outer offices be "generalist" within their professional discipline, and fulfill functions for other departments as required to ensure service provision. The team decided that this option needs to be further explored. It was agreed that staff in Brockville and Smiths Falls offices would strike a balance between responding to the urgent needs of other departments and playing more of a "specialist" role; There is an added benefit to having the competencies that come with specialization. These views are in keeping with staff

recommendations. Once again these approaches to service provision were noted to be part of the broader issue of interdepartmental collaboration and the prioritization of program delivery based on need and impact, and will be addressed by the development of policy.

The desire to convert “job-splitting” positions (positions which report to more than one director) into whole positions within departments was expressed by some staff in the focus groups. The review team agreed that such positions will be reviewed on an ongoing basis and converted into whole positions within departments where appropriate to meet the needs of the agency.

The team agreed that the organizational structure should be evaluated in one year’s time. This task would be incorporated into the Health Unit Operational Plan 2003. The process would be led by the Quality Improvement Department and the methods involved would be developed and communicated to Board members and staff well in advance.

Comments:

The decision to make changes to our organizational structure is no doubt an important one which the Board of Health should take some time to consider. This decision should be made taking into account the findings of the review of our Long Range Resources Plan which will be brought forward to Board for its meeting on November 28th. In conjunction with decisions made on our structure and our Long Range Resources Plan, we will need to plan for our needs for office space as well. It should be noted that planning for space needs becomes more manageable once decisions are made with regard to staffing in the years to come.

Recommendation:

It is recommended that the Board of Health receive this report as information, in anticipation of receiving a review of our Long Range Resources Plan on November 28th.

Respectfully submitted,

THE CORPORATION OF THE LEEDS, GRENVILLE
AND LANARK DISTRICT HEALTH UNIT

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Appendix A: Proposed Organizational Chart Leeds, Grenville and Lanark District Health Unit

